

ENROLLMENT FORM FOR STUDY ABROAD HEALTH INSURANCE

Academic Policy Year: 2009-2010

*PLEASE RETURN TO: SUITE 223 STUDENT UNION, SUNY BUFFALO-NORTH CAMPUS, BUFFALO, NY 14260
PH: (716) 645-3036 / FAX: (716) 645-3465 / PDF E-MAIL: ASKSMI@BUFFALO.EDU*

Destination of Domestic Student/Faculty Abroad: _____
UB Faculty Advisor for Program Abroad: _____ Advisor E-mail: _____

LAST NAME	FIRST NAME	MI	DATE OF BIRTH: ____ / ____ / ____	
			Mo. Day Year	
PREFERRED MAILING ADDRESS	CITY	STATE	ZIP CODE	
(____) _____ - _____	E-MAIL ADDRESS	UB DEPT OR PROGRAM	HOME COUNTRY	
_____ - _____	_____ - _____ - _____			
UB PERSON NUMBER	SOCIAL SECURITY NUMBER <small>(Non-UB students only)</small>	<input type="radio"/> MALE or <input type="radio"/> FEMALE		
CURRENT EDUCATIONAL LEVEL: (CIRCLE ONE) UNDERGRAD GRADUATE PROFESSIONAL FACULTY/STAFF/RESEARCH				

Insurance periods cover from the 15th of one month to the 14th of the next month. For example, if you want coverage from Feb. 1 to Mar. 10, you would have to pay for two whole months (enrolling 15th January through 14th March). There are no exceptions without prior approval of the insurance office.

DATES OF COVERAGE : FROM ____ / 15 / ____ TO ____ / 14 / ____ <i>Alternative Coverage Dates: FROM ____ / ____ / ____ TO ____ / ____ / ____</i> <small>(Requires Prior Administrative Approval From SMI Office to Sponsoring Department—not optional to participant.)</small>

FULL YEAR	FALL	SPRING AND SUMMER	SUMMER	MONTHLY
	8/15/09 - 1/14/10		5/15/10 - 8/14/10	
8/15/09-8/14/10	OR SPRING	1/15/10 - 8/14/10	OR 3 MONTHS	X/15/XX - X/14/XX
	1/15/10 - 6/14/10		X/15/XX - X/14/XX	
\$994.75	\$414.50	\$580.50	\$248.50	\$83.00

Please indicate payment (circle one): **UB STUDENTS MUST HAVE THEIR STUDENT ACCOUNT BILLED.**

Cash, Check or Money Order Enclosed Make check payable to SUNY at Buffalo	Please Bill My Student Account <small>(double check your person number above)</small>	Please Invoice My Department <small>(prior approval from insurance office required)</small>
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I wish to enroll on the SUNY International Health Insurance program for the above period. I understand this includes payment of the insurance premium and a non-refundable administrative fee. I understand that by signing this enrollment form I decline the option of waiving the international insurance plan for my SUNY sponsored International Exchange or Study Abroad.

APPLICANT'S SIGNATURE	TODAY'S DATE: ____ / ____ / ____ Mo. Day Year
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FOR OFFICE USE ONLY:

Check number: _____ Receipt number: _____ Payment amount \$: _____ Received by: _____

Effective Date ____ / ____ / ____ Expiration Date ____ / ____ / ____ Class: 5

OSA: _____ HTH: _____ Previously GSEU / RF? YES NO

Roster Update: _____